

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF MEDICAID CLINICAL
LABORATORY SERVICES
CALENDAR YEARS 1993 AND 1994**

**WISCONSIN DEPARTMENT OF HEALTH
AND SOCIAL SERVICES
MADISON, WISCONSIN**



**JUNE GIBBS BROWN
Inspector General**

**FEBRUARY 1996
A-05-95-00035**



DEPARTMENT OF HEALTH AND HUMAN SERVICES

REGION V
105 W. ADAMS ST.
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OFFICE OF
INSPECTOR GENERAL

Common Identification No. A-05-95-00035

February 29, 1996

Mr. Joe Leean, Secretary
Department of Health and Social Services
P.O. Box 7850
Madison, Wisconsin 53707-7850

Dear Mr. Leean:

This report presents the results of our audit of Department of Health and Social Services (State agency) reimbursement for clinical laboratory services under the Medicaid program. The objective of our audit was to determine the adequacy of procedures and controls over the processing of Medicaid payments to providers for clinical laboratory tests. Our review was limited to clinical laboratory services involving certain chemistry and hematology tests set forth in APPENDIX B.

Our audit disclosed that the State agency was reimbursing providers for laboratory services that were not properly grouped together (bundled into a panel) or were duplicated for payment purposes. Although the State agency established a system of edits which covered 85 percent of the procedure codes included in our review, the absence of certain edits allowed some improper payments to be made to providers. Specifically, the State agency's claims processing system did not edit for all applicable procedure codes, places and types of service, and unbundling involving more than one claim. Further, the Medicaid laboratory fees incorporated in the system often exceeded the corresponding Medicare fees during the latter part of calendar year (CY) 1994. We also determined that improper provider reimbursements resulted because the State agency did not inform medical providers of all procedure codes that were subject to bundling or duplicative. Although the State agency implemented a new Medicaid claims editing system, effective for claims dated April 1, 1995 or later, we cannot express an opinion on whether the new system corrects all the conditions found in our audit.

We randomly selected 100 instances involving claims with potential payment errors from a sample population valued at \$1,371,810 that was extracted from the CY 1993 and 1994 paid claims files. We found that 89 of the 100 sampled items were overpaid. Each instance represents a potential payment error in which the State agency paid a provider for clinical laboratory tests (on behalf of the same beneficiary on the same date of service) on an individual test basis, instead of as part of a group, or for tests which were duplicative of each other. Projecting the results of our statistical sample over the population using standard statistical methods, we estimate the State agency overpaid providers \$569,093 (Federal share \$343,561) for chemistry and hematology tests. At the 90 percent confidence level, the precision of this estimate is plus or minus \$84,601 (14.87 percent).

We are recommending that the State agency: (1) ensure that its edits detect and prevent payments for unbundled services and billings which contain duplicative tests by addressing the specific overpayment causes enumerated in this report; (2) ensure, in the future, that its Medicaid laboratory fees are not higher than Medicare laboratory fees; (3) update and clarify its instructions to providers to include additional procedure codes which are subject to edits for unbundled and duplicate tests; (4) determine the amount of potential overpayment by provider and obtain recoveries from those providers with the largest total potential overpayments; and (5) make adjustments for the Federal share of the amounts recovered by the State agency on its Quarterly Report of Expenditures to the Health Care Financing Administration (HCFA). Based on our audit, we estimate that \$569,093 (Federal share \$343,561) could be recovered from all providers for CYs 1993 and 1994.

In response to our draft report, State agency officials commented that the audit scope was not based on federal Medicaid requirements. They believe many of the findings were based on incorrect application of coding conventions and misunderstandings about Wisconsin Medicaid claims processing and reimbursement policies. Since our audit period, they have expanded their cost containment efforts by implementing new software which should further detect and correct unbundled, mutually exclusive, and incidental services. Because State agency officials believe no violations of Medicaid requirements occurred and improvements have been made, they feel the State agency should not be liable for recovery of projected overpayments.

The audit was based on the federal requirement that Medicaid payments for clinical laboratory tests cannot exceed the amount recognized by Medicare. To ensure compliance, the state agencies must know not just the Medicare fee for each procedure code but which procedure code and fee Medicare would reimburse when certain code combinations are claimed. The coding conventions used in the audit were primarily based on the Physicians' Current Procedural Terminology (CPT) guidelines for bundling automated, multichannel chemistry tests and the CPT definitions for hematology procedure codes in our review. We recognized the State agency's implementation of new software for claims processing but this enhancement occurred after the audit period and does not affect the amount of projected overpayments. As a result, we believe our recommendations remain valid.

INTRODUCTION

BACKGROUND

Clinical laboratory services include chemistry and hematology tests. Laboratory tests are performed on a patient's specimen to help physicians diagnose and treat ailments. The testing may be performed in a physician's office, a hospital laboratory, or by an independent laboratory.

Chemistry tests involve the measurement of various chemical levels in the blood while hematology tests are performed to count and measure blood cells and their content. Chemistry tests frequently performed on automated equipment are grouped together and reimbursed at a panel rate. Chemistry tests are also combined under problem-oriented classifications (referred to as organ panels). Organ panels were developed for coding purposes and are to be used when all of the component tests are performed. Many of the component tests of organ panels are also chemistry panel tests.

Hematology tests that are grouped and performed on an automated basis are classified as profiles. Automated profiles include hematology component tests such as hematocrit, hemoglobin, red and white blood cell counts, platelet count, differential white blood cell counts and a number of additional indices. Indices are measurements and ratios calculated from the results of hematology tests. Examples of indices are red blood cell width, red blood cell volume and platelet volume.

Within broad federal guidelines, states design and administer the Medicaid program under the general oversight of HCFA. Claims processing is the responsibility of a designated Medicaid agency in each state. Many states use outside fiscal agents to process claims. States may elect to participate in the HCFA Medicaid Statistical Information System (MSIS). The MSIS is operated by HCFA to collect Medicaid eligibility and claims data from participating states. States participating in MSIS provide HCFA with two quarterly computer files consisting of an eligibility and a paid claims file. The eligibility file contains specified data for persons covered by Medicaid, and the paid claims file contains adjudicated claims for medical services reimbursed with Medicaid funds.

The State Medicaid Manual, Section 6300.1 states that federal matching funds will not be available to the extent a state pays more for outpatient clinical laboratory tests performed by a physician, independent laboratory, or hospital than the amount Medicare recognizes for such tests. In addition, Section 6300.2 states that payment for clinical laboratory tests under the Medicaid program cannot exceed the amount recognized by the Medicare program. Under Medicare, clinical laboratory services are reimbursed at the lower of the fee schedule amount or the actual charge. The Medicare carrier (the contractor that administers Medicare payments to physicians and independent laboratories) maintains the fee schedule and provides it to the state Medicaid agency in its locality to allow comparison with Medicaid fees.

SCOPE

Our audit was conducted in accordance with generally accepted government auditing standards. The objective of our audit was to determine the adequacy of procedures and controls over the processing of Medicaid payments to providers by the State agency for certain clinical laboratory services. Our review was limited to clinical laboratory services involving the chemistry and hematology tests shown in APPENDIX B.

To accomplish our objective, we:

- o reviewed State agency policies and procedures for processing Medicaid claims from providers of clinical laboratory services;
- o extracted from HCFA's MSIS, CY 1993 and 1994 paid claims files, payments totaling \$4,600,769 for chemistry and hematology tests. Of this amount, \$1,371,810 represented instances involving claims that contained potentially unbundled or duplicate charges for chemistry and hematology tests (See Appendices A and B). We tested the reliability of computer generated **output** by comparing data to source documents for our sampled items. We did not, however, assess the completeness of data in HCFA's MSIS files nor did we evaluate the adequacy of the input controls;
- o selected a random statistical sample of 50 instances involving chemistry claims from a population of 35,306 instances containing chemistry tests valued at \$526,291 and 50 instances involving hematology claims from a population of 51,382 instances containing hematology tests valued at \$845,519. These instances were taken from a universe of payments representing claims for more than one chemistry panel or hematology profile, or for a panel or profile and individual tests, or for more than one individual test for the same beneficiary on the same date of service by the same provider;
- o reviewed the randomly selected instances and supporting documentation from the State agency to determine the propriety of the payment;
- o utilized a variable sample appraisal methodology to estimate the amount of overpayment for the chemistry and hematology tests in our audit.

Our review of internal controls was limited to an evaluation of the claims processing function related to processing claims for clinical laboratory services. Specifically, we reviewed State agency policies and procedures and instructions to providers pertaining to the billing of clinical laboratory services. We also reviewed State agency documentation relating to automated and manual edits for bundling of chemistry tests and the detection of duplicate claims for hematology tests. We limited our review to claims paid by the State agency during CYs 1993 and 1994. Details of the methodology used in selecting and appraising the sample are contained in APPENDIX A to this report.

We found that the items tested were in compliance with applicable laws and regulations except for the matters discussed in the RESULTS OF REVIEW section of this report.

We performed our review between April and July 1995. During this period, we visited the State agency office in Madison, Wisconsin. The State agency uses a fiscal agent, EDS, to edit, process and pay Medicaid claims. We did not perform any fieldwork at the fiscal agent. The results of our review were discussed with State agency officials and their written comments to our draft report are attached in APPENDIX C.

RESULTS OF REVIEW

Although the State agency established a system of edits which covered 85 percent of the procedure codes included in our review, the absence of certain edits allowed some improper payments to be made to providers. Our examination of 100 instances of potential payment errors disclosed that the State agency's claims processing system did not edit for all applicable procedure codes (52 instances), places of service (47 instances) and types of service (2 instances), and unbundling involving more than 1 claim (9 instances). Further, in some instances, the Medicaid fees for the bundled procedures improperly exceeded the corresponding Medicare panel fees (29 instances). Also, the State agency did not inform medical providers of all procedure codes subject to bundling and duplication (52 instances).

A 1993 study by a private contractor found the State agency had overpaid Medicaid claims for unbundled laboratory services. Based in part on that report, the State agency implemented a new Medicaid claims editing system with an enhanced procedure code review, effective for claims with dates of service April 1, 1995 or later. We cannot express an opinion on whether the new system has corrected all conditions found in our audit.

The results of our review were based on a statistical sample and projection of results. Using computer applications, we extracted claims data with applicable chemistry and hematology procedure codes from HCFA's MSIS database for CYs 1993 and 1994. This extract yielded a total of \$4,600,769 in payments for chemistry panel tests and hematology profile tests. This total consisted of 238,730 chemistry tests with a value of \$1,747,739 and 397,532 hematology tests valued at \$2,853,030 (See Appendices A and B for details). From this extract, we identified instances of potential payment errors made to providers for services rendered to the same beneficiary on the same date of service. The population of claims with potential payment errors totaled \$1,371,810 (\$526,291 for chemistry tests and \$845,519 for hematology tests).

We randomly selected a sample of 100 instances (50 instances involving claims with chemistry panel tests and 50 instances involving claims with hematology tests) valued at \$1,614 from the population of claims with potential payment errors totaling \$1,371,810. Our review showed that 89 of the 100 claims were overpaid. Projecting the results of our statistical sample to the population using standard statistical methods, we estimate the State agency overpaid providers \$569,093 (Federal share \$343,561) for chemistry and hematology tests during the 2-year audit period. At the 90 percent confidence level, the precision of this estimate is plus or minus \$84,601 (14.87 percent).

Chemistry Panel Tests

Our review of 50 instances involving claims containing potentially unbundled charges for chemistry tests disclosed 41 instances which contained overpayments. The sample of 50 instances were selected on a scientific random basis from a population of 35,306 instances involving claims containing potentially unbundled chemistry panel tests valued at \$526,291.

Based on our statistical sample, we estimate the State agency overpaid providers \$280,676 (Federal share \$169,444) for unbundled chemistry panel tests.

Section 5 114.1 .L.2 of the Medicare Carriers Manual states that if the carrier receives claims for laboratory services in which the physician or laboratory has separately billed for tests that are available as part of an automated panel test, and, in the carrier's judgement, such panel tests are frequently performed and available for physicians' use, the carrier should make payment at the lesser amount for the panel. The limitation that payment for individual tests not exceed the payment allowance for the panel is applied whether a particular laboratory has or does not have the automated equipment.

We determined that some providers in Wisconsin were overpaid for chemistry tests because the State agency's claims processing system did not:

1. edit claims with place of service code 1 for hospital inpatient (20 instances) or code 2 for hospital outpatient (18 instances) (total 38 instances).
2. edit for 2 procedure codes (80050 and 80058) after July 1, 1993 as directed by HCFA and 1 procedure code (82550) until August 1994 (5 instances).
3. edit for unbundled procedures involving more than 1 claim (4 instances).
4. edit for type of service code C, which is ancillaries for hospitals (in this case, out-of-state hospitals) (2 instances).
5. include three procedure codes (82374 for physicians; 82550 and 84160 for independent laboratories) subject to bundling in the State agency's instructions to medical providers (5 instances).

Our review disclosed the Medicaid bundled panel fee in the claims processing system improperly exceeded the Medicare panel fee in 8 of the 41 overpayment instances. A review of physician fees for 39 chemistry procedures included in this audit disclosed the Medicaid fees for 35 procedures were higher than the Medicare fees during July through December 1994. A State agency official told us that, due to an oversight, the Medicare fees were not considered when setting the Medicaid fees for this period. The oversight occurred, in part, because the Medicare carrier notified the Medicaid fiscal agent of the CY 1994 Medicare laboratory fees earlier than normal and used a newsletter rather than the usual data tape for the notification.

Other Matters. In addition to the causes cited above for the 41 overpayments, we noted the State agency's claims processing system did not edit for quantities of 2 unbundled chemistry procedure codes (8 instances). While the Medicare Carriers Manual, Section 5 114.1. L.2. does not require bundling quantities of 2 tests, the Manual states that carriers are not precluded from performing such bundling using procedure code 80002. We believe the State agency should consider bundling two chemistry tests. Although we did not include the 8

instances in our statistical projection of overpayments for the 50 sample items, we separately estimated potential overpayments for these 8 items to be \$28,626 (Federal share \$17,282) for the audit period. At the 90 percent confidence level, the precision of this estimate is plus or minus \$16,883 (58.98 percent). A State agency official told us the State may not have edited for unbundled quantities of two chemistry tests because some tests may be appropriately performed more than once a day, and thus, should not be bundled. However, the lack of such an edit can result in payment for two different tests, as well as, payment for the same test twice in one day.

With respect to the State agency instructions to physicians, the narrative body of Part K of the Wisconsin Medical Assistance Program Provider Handbook does not specifically state that chemistry tests should be bundled. The bundling requirement for chemistry tests is, instead, contained in an appendix to Part K. To avoid oversights which could result in overpayments, we believe the Part K narrative instructions should also contain the requirement to bundle chemistry tests.

We discussed the results of our review with a State agency official. We provided him with a list of sampled claims and the procedure codes omitted from edits and provider instructions. The State agency's written comments are summarized in STATE AGENCY COMMENTS AND OIG RESPONSES (Pages 9-13) with the complete response attached as APPENDIX C of this report.

Hematology Profiles

Our review of 50 instances involving claims containing hematology profiles disclosed that 48 of these instances contained paid duplicate charges. The remaining two instances also contained duplicate charges but, for other reasons, did not result in overpayments. These 50 instances were selected on a scientific random basis from a population of 5 1,382 instances involving claims containing potentially duplicated hematology tests valued at \$845,519. Based on our statistical sample, we estimate the State agency overpaid providers \$288,417 (Federal share \$174,117) for duplicated hematology tests.

Section 7103 of the Medicare Carriers Manual states that a provider is liable for overpayments it receives. In addition, Section 7103.1 B states that the provider is liable in situations when the error is due to overlapping or duplicate bills.

Hematology tests are performed- and billed in groups or combinations of tests known as profiles; however, hematology tests can also be performed individually. Duplicate billings occur when individual hematology tests are billed for the same patient for the same date of service as a hematology profile which includes the individual test. Duplicate billings also occur when two hematology profiles are billed for the same patient and same date of service. In addition, duplicate billings occur when hematology indices are billed with a hematology profile. Hematology indices are calculations from the results of hematology tests. Since hematology indices are calculated along with the performance of each hematology profile, a separate billing for hematology indices results in a duplicate billing.

The State agency did not detect all claimed duplicate hematology charges and, as a result, overpaid some claims. The condition **occurred** because the State agency's claims processing system did not:

1. edit for 7 of the hematology procedure codes (85023, 85024, 85025, 85027, 85029, 85030 and 85595) (47 instances).
2. include these same 7 procedure codes in the instructions to medical providers (47 instances).
3. edit claims with place of service code 1 for hospital inpatient (4 instances) or code 2 for hospital outpatient (5 instances).
4. edit for unbundled procedures involving more than 1 claim (5 instances).

Our review also disclosed the Medicaid fee improperly exceeded the Medicare fee in 21 of the 48 overpayment instances. A review of physician fees for the 14 hematology procedures included in this audit disclosed the Medicaid fees for 11 procedures were higher than the Medicare fees during July through December 1994. A State agency official told us that, due to an oversight, the Medicare fees were not considered when setting the Medicaid fees for this period. The oversight **occurred**, in part, because the Medicare carrier notified the Medicaid fiscal agent of the CY 1994 Medicare laboratory fees earlier than normal and used a newsletter rather than the usual data tape for the notification.

We provided the State agency with a list of sampled claims, the procedure codes omitted from edits and provider instructions, and discussed the results of our review with a State agency official. The State agency's written comments are summarized in STATE AGENCY COMMENTS AND OIG RESPONSES (Pages 9-13) with the complete response attached as APPENDIX C of this report.

State Agency Actions After Audit Period

Subsequent to our audit period, the fiscal agent installed a new Medicaid claims editing system for claims with dates of service on or after April 1, 1995. The new system, called **ClaimCheck**, may correct some causes of overpayment in claims for unbundled or duplicated laboratory fees. For proprietary reasons, we were unable to review the detailed edit logic for **ClaimCheck**. Based on our limited review of the manner in which **ClaimCheck** processed some procedure codes used in our audit, it appears that not all laboratory procedures are being properly identified and bundled by the system. However, due to the very limited scope of our testing, we cannot express an opinion as to whether the State agency's new system corrects all the conditions that we found in our audit. We believe the State agency should further examine the causes of overpayment we identified to determine which edits, if any, could still be implemented.

RECOMMENDATIONS

We recommend that the State agency:

(1) Ensure its edits detect and prevent payments for unbundled services and billings which contain duplicative tests by addressing the specific overpayment causes enumerated in this report.

(2) Ensure, in the future, that Medicaid laboratory fees do not exceed Medicare laboratory fees.

(3) Update and clarify its instructions to providers to include additional procedure codes which are subject to edits for unbundled and duplicative tests.

(4) Determine the amount of potential overpayment by provider and obtain recoveries from those providers with the largest total potential overpayments. We estimate overpayments amounting to \$569,093 (Federal share \$343,561) could be recovered from all providers for CYs 1993 and 1994.

(5) Make adjustments to its Quarterly Report of Expenditures for the Federal share of amounts recovered by the State agency.

STATE AGENCY COMMENTS AND OIG RESPONSES

The State agency responded to our draft report in a letter dated October 31, 1995. They provided comments on the audit in general, as well as, specific comments pertaining to the causes of our findings. We have summarized the State agency's comments and our responses in the following paragraphs. The entire text of the written response is attached as APPENDIX C to this report.

GENERAL COMMENTS

State Agency Comments

State agency officials indicated the audit scope and focus were not based on federal Medicaid requirements, but rather, on best practices, standard coding conventions and Medicare reimbursement requirements. They stated there are no federal Medicaid requirements to limit reimbursement for unbundled lab panels and the Medicare Carrier's Manual cited as criteria is not applicable to Medicaid. Absent any federal regulations, Wisconsin implemented its own reimbursement policies based on standard coding conventions and best practices.

The State agency contends it is a leader in the use of sound reimbursement and best practices in Medicaid claims processing and has demonstrated its performance by excellent results in the MMIS Systems Performance Reviews. In addition, they have expanded cost containment efforts by implementing **ClaimCheck** software to further detect and correct unbundled, mutually exclusive, and incidental services. Because there were no violations of Medicaid requirements and improvements have been made in claims processing, the State agency believes it should not be liable for recovery of projected overpayments.

OIG Response

The coding conventions used in the audit were primarily based on the CPT guidelines for bundling automated, multichannel chemistry tests and the CPT definitions for the hematology procedure codes in our review (see APPENDIX B). In addition, a 1993 memorandum from HCFA officials described how Medicare carriers and Medicaid state agencies should reimburse two chemistry panel tests (80050 and 80058).

Section 6300 of the State Medicaid Manual states federal matching funds will not be available to the extent a state pays more for outpatient clinical laboratory tests than the amount Medicare recognizes for such tests. Though not specifically stated, the inference is that state agencies must know not just the Medicare fee amount for each procedure code but also which procedure code and fee Medicare would reimburse when certain code combinations were claimed. Portions of the Medicare Carriers Manual are cited in the report to explain how Medicare carriers need to ensure they do not reimburse unbundled or duplicative lab tests.

We are unable to comment on the State agency's leadership in Medicaid claims processing or its performance in MMIS Systems Performance Reviews because of the limited scope of our audit. We recognized in the report that the State agency's edits and instructions to providers included many of the procedure codes audited and that **ClaimCheck** was implemented after the audit period. However, edits were not in place for some laboratory procedure codes claimed during the audit period and overpayments resulted. Our report shows an area for cost recoveries and future cost savings in the Medicaid program.

SPECIFIC COMMENTS

State Agency Comments

Officials from the State agency provided specific comments directed at the causes of overpayments reported. They believe many of the findings and projected overpayments are based on incorrect application of coding conventions and misunderstandings about Wisconsin Medicaid claims processing and reimbursement policies. As a result, they feel our projected overpayments are overstated. Their comments are summarized by topic as follows:

- ▶ **Hospital Inpatient and Outpatient Places of Service** - Lab services billed in a hospital setting are for the physician's professional component (interpretation) of the lab result. The billing and reimbursement limits for lab panels are not applicable to the professional component and these cases should not be considered overpayments. Effective May 1994, Wisconsin Medicaid no longer reimbursed most laboratory services billed strictly as professional services.
- ▶ **Edits for Chemistry Codes 80050, 80058 and 82550 and Hematology Codes 85023, 85024, 85025, 85027, 85029, 85030 and 85595** - These chemistry claims are not overpayments because codes 80050 and 80058 are not automated multichannel lab profiles and code 82550 is not routinely included in profiles as defined in either the CPT-4 coding handbook or the Medicare Carriers Manual. There are no federal requirements to monitor the hematology codes cited; therefore, the State should not be held liable to recover these overpayments. The State agency will use **ClaimCheck** to monitor hematology services in a more comprehensive manner.
- ▶ **Services Submitted on Multiple Claims** - Most lab services performed on one day are billed on one claim form. It is not cost effective to edit lab services billed on separate claims during a claims processing cycle; however, the State agency plans to use **ClaimCheck** retrospectively to identify and correct unbundling on multiple claims.
- ▶ **Type of Service C, Ancillaries for Hospitals** - It is not necessary to apply claims edits to outpatient hospital services because the services are reimbursed on a flat rate per visit regardless of the type or number of services provided. The detailed charges are used only to document services provided and to support hospital cost audits. These two cases are not overpayments.
- ▶ **Instructions to Providers Did Not Include Chemistry Codes 82374, 82550 and 84160 or Hematology Codes 85023, 85024, 85025, 85027, 85029, 85030 and 85595** - The Wisconsin Medicaid physician handbook has instructed providers to use the CPT-4 coding conventions for guidance on billing Medicaid. This alleviates the need to publish redundant and ever changing lists of codes in the provider manuals.
- ▶ **Medicaid Lab Reimbursement Fees Exceeded Medicare Fees** - Historically, Medicaid fees have been lower than Medicare; therefore, the extent and amount of potential overpayments will be minimal. The State agency agreed to correct Medicaid fees immediately to ensure they do not exceed Medicare fees.

Based on these comments, the State agency believes the amount of projected overpayments could be reduced significantly. Consequently, they have recommended that HCFA not pursue recovery of overpayments in Wisconsin.

OIG Response

The coding conventions used in the audit are supported by guidance in the CPT handbook and a 1993 HCFA memorandum. While our coding conventions differ from the State agency's procedures, we have disclosed an area for cost recovery and future cost savings for both the State and federal governments. The projected overpayments were reduced for one issue but we continue to believe the remaining instances of unbundled and duplicative lab services reported should be considered overpayments. Our responses to the State agency's comments are presented in the same order as discussed on the previous page.

- ▶ **Hospital Inpatient and Outpatient Places of Service** - All but 2 of the 47 cases reported represent claims for the professional (interpretation) component of the laboratory fee. We believe these cases are overpayments because physicians received higher reimbursement by claiming the professional component fee for each lab test separately (40% of each test fee) than they would have received if the tests were bundled into one panel and reimbursed at the single, lower panel fee. In addition, the State agency's policy allowing reimbursement for the professional component of each test performed in a hospital outpatient setting is inconsistent with its policy to reimburse lab services performed in a doctor's office or independent lab at the lower, bundled panel fee. The State agency corrected this condition in May 1994 by no longer allowing reimbursement of claims for the professional component only.
- ▶ **Edits for Chemistry Codes 80050, 80058 and 82550 and Hematology Codes 85023, 85024, 85025, 85027, 85029, 85030 and 85595** - Codes 80050 (no overpayments in our sample) and 80058 are automated multichannel tests which are to be reimbursed as panel fees according to an April 8, 1993 HCFA memorandum. After issuing our draft report, we learned the State agency did not receive the memorandum until June 11, 1993. As a result, we revised our report to exclude code 80058 from bundled tests if the claim was paid before July 1, 1993. The amount of projected overpayments reported has been reduced from \$618,896 to \$569,093 to reflect this change.

Chemistry code 82550 was included in the audit because some Medicare carriers (including Wisconsin) and other state agencies have included this code in their bundling edits. The State agency took corrective action by adding this code to its edits in August 1994.

The hematology code combinations in the audit are duplicative of each other according to the procedure code definitions in the CPT handbook. We believe there is adequate support for considering such duplications to be overpayments and suggest the State agency ensure that **ClaimCheck** edits for these code combinations in the future.

- ▶ **Services Submitted on Multiple Claims** - Since only 10 percent of our projected overpayments pertain to this condition, we agree it is not cost effective to compare multiple claims during routine claims processing. State agency officials told us they intend to use **ClaimCheck** at the end of each year to review claims for unbundled and duplicative lab services paid on multiple claims during the year. Recoveries from providers will be requested. We believe this method is reasonable.
- ▶ **Type of Service C, Ancillaries for Hospitals** - State agency officials subsequently found that these two cases (for out-of-state or “border-status” hospitals) were reimbursed at the lower of the amount claimed or the maximum Medicaid fee allowed for each individual test, not a flat rate per visit. Further, the State agency subsequently agreed it does not perform cost audits of out-of-state hospital outpatient services. Since the total paid for the unbundled tests exceeded the Medicaid bundled fee, we consider these cases to be overpayments.
- ▶ **Instructions to Providers Did Not Include Chemistry Codes 82374, 82550 and 84160 or Hematology Codes 85023, 85024, 85025, 85027, 85029, 85030 and 85595** - Although the State agency directed providers to use the CPT handbook for guidance on coding conventions, it also published a Provider Handbook which included instructions on billing for lab services. Contrary to the State agency’s written response, the Provider Handbook contains lists of procedure codes that should be bundled or are duplicative and the Handbook was periodically updated. The Handbook did not, however, include the procedure codes cited above.
- ▶ **Medicaid Lab Reimbursement Fees Exceeded Medicare Fees** - Less than 2 percent of our projected overpayments resulted from the difference between Medicaid and Medicare fees. Therefore, we reworded our recommendation to direct the State agency to ensure future Medicaid fees do not exceed Medicare fees. The State agency agreed to take this corrective action in its written response.

In summary, the State agency had edits in place for 85 percent of the procedure codes in our audit and has taken some corrective actions both during and after the audit period. However, we continue to believe the conditions reported represent areas for improvement in claims processing and that recoveries from providers with large potential overpayments should be pursued.

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A copy of this report will be forwarded to the action official noted below for his review and any action deemed necessary. Final determination as to actions taken on all matters reported will be made by the HHS action official named below. **We request that you respond to the HHS action official within 30 days from the date of this report.** Your response should present any comments or additional information that you believe may have a bearing on the final determination.

Page 14 - Mr. Joe LEEAN

In accordance with the principles of the Freedom of Information Act (Public Law 90-23), OIG/OAS reports issued to the Department's grantees and contractors are made available, if requested, to members of the press and general public to the extent information contained therein is not subject to exemptions in the Act which the Department chooses to exercise. (See 45 CFR Part 5.)

To facilitate identification, please refer to Common Identification Number A-05-95-00035 in all correspondence relating to this report.



Paul Swanson
Regional Inspector General
for Audit Services

Attachments:

APPENDIX A - Sample Methodology
APPENDIX B - Clinical Laboratory Procedures Reviewed
APPENDIX C - State Agency Written Comments

Direct Reply to HHS Action Official:

Mr. David Dupre, Associate Regional Administrator
Division of Medicaid
Health Care Financing Administration
105 West Adams Street, 14th Floor
Chicago, Illinois 60603

SAMPLE METHODOLOGY

From the Health Care Financing Administration's (HCFA) Medicaid Statistical Information System (MSIS) paid claims file for calendar years (CY) 1993 and 1994, we utilized computer applications to extract all claims containing:

1. automated multichannel chemistry panels and panel tests for chemistry procedure codes listed in the Physician's Current Procedural Terminology (CPT) handbook. (See APPENDIX B)
2. hematology profiles and component tests normally included as part of a hematology profile for hematology procedure codes listed in the CPT handbook. (See APPENDIX B)

The above file extract yielded a **total** of **\$4,600,769** in payments for chemistry and hematology tests in **CYs** 1993 and 1994. This total consisted of 238,730 records totaling **\$1,747,739** relating to chemistry panel tests and 397,532 records totaling **\$2,853,030** relating to hematology profile tests.

We then performed computer applications to extract all records for the same individual for the same date of service with **HCFA's** Common Procedure Coding System (HCPCS) line item charges for:

1. more than one different chemistry panel; a chemistry panel and at least one individual panel test; or two or more panel tests.
2. more than one automated hematology profile under different profile codes; more than one unit of the same profile; a component normally included as part of a profile in addition to the profile; or hematology indices and a profile.

This extract resulted in a sample population totaling **\$1,371,810** consisting of two strata. The first strata consisted of 35,306 instances totaling \$526,291 for potentially unbundled chemistry panel tests. The second strata consisted of 51,382 instances totaling \$845,519 for potentially duplicate hematology profile tests. Each instance is a potential payment error in which the State agency paid providers for clinical laboratory tests (on behalf of the same beneficiary on the same date of **service**) which were billed individually instead of as part of a group, or were duplicative of each other.

On a scientific stratified selection basis, we examined 100 instances involving claims from two strata. The first stratum consisted of a randomly generated statistical sample of 50 potentially unbundled instances involving chemistry panel tests totaling \$843. The second stratum consisted of a randomly generated statistical sample of 50 potentially duplicate instances involving hematology profile or profile component tests totaling \$771.

For the sample items, we requested and reviewed supporting documentation from the State agency consisting of copies of physician, hospital or independent laboratory claims, electronic paid claims detail for claims submitted electronically, explanation of benefits paid, and related paid claims histories.

We utilized a standard scientific estimation process to quantify overpayments for unbundled chemistry panel tests and duplicate hematology profile tests as shown in the schedule below.

Stratum	Number of Items	Number Sampled	Examined Value	Number of Errors	Error in Sample	Estimated Recovery
Chemistry Tests	35,306	50	\$843	41	\$397	\$280,676
Hematology Tests	51,382	50	\$771	48	\$281	\$288,417
Totals	86,688	100	\$1,614	89	\$678	\$569,093

The results of the scientific sample of Stratum 1, chemistry tests, disclosed that 41 of 50 instances we reviewed represented overpayments for unbundled chemistry panel tests. Projecting the results of the statistical sample over the population using standard statistical methods, we estimate that \$280,676 (Federal share \$169,444) paid for unbundled chemistry panel tests can be recovered. At the 90 percent confidence level, the precision of this estimate is plus or minus \$82,733 (29.48 percent).

The results of the scientific sample of Stratum 2, hematology tests, disclosed that 48 of the 50 instances we reviewed contained duplicate payments for hematology profiles and profile component tests. Projecting the results of the statistical sample over the population using standard statistical methods, we estimate that \$288,417 (Federal share \$174,117) in duplicate payments for hematology profile tests can be recovered. At the 90 percent confidence level, the precision of this estimate is plus or minus \$24,312 (8.43 percent).

CLINICAL LABORATORY PROCEDURES REVIEWED
AUTOMATED MULTICHANNEL CHEMISTRY PANEL TEST HCPCS

Chemistry Panel CPT Codes

80002 1 or 2 clinical chemistry automated multichannel test(s)
80003 3 clinical chemistry automated multichannel tests
80004 4 clinical chemistry automated multichannel tests
80005 5 clinical chemistry automated multichannel tests
80006 6 clinical chemistry automated multichannel tests
80007 7 clinical chemistry automated multichannel tests
80008 8 clinical chemistry automated multichannel tests
80009 9 clinical chemistry automated multichannel tests
80010 10 clinical chemistry automated multichannel tests
80011 11 clinical chemistry automated multichannel tests
80012 12 clinical chemistry automated multichannel tests
80016 13-16 clinical chemistry automated multichannel tests
80018 17-18 clinical chemistry automated multichannel tests
80019 19 or more clinical chemistry automated multichannel tests
80050 General Health Panel
80058 Hepatic Function Panel

Chemistry Tests Subject to Panelling (34 CPT Codes)

1.	Albumin	82040
2.	Albumin/globulin ratio	84170
3.	Bilirubin Total OR Direct	82250
4.	Bilirubin Total AND Direct	8225 1
5.	Calcium	82310, 82315, 82320, 82325
6.	Carbon Dioxide Content	82374
7.	Chlorides	82435
8.	Cholesterol	82465
9.	Creatinine	82565
10.	Globulin	82942
11.	Glucose	82947
12.	Lactic Dehydrogenase (LDH)	83610, 83615, 83620, 83624
13.	Alkaline Phosphatase	84075
14.	Phosphorus	84100
15.	Potassium	84132
16.	Total Protein	84155, 84160
17.	Sodium	84295
18.	Transaminase (SGOT)	84450, 84455
19.	Transaminase (SGPT)	84460, 84465
20.	Blood Urea Nitrogen (BUN)	8 4 5 2 0
21.	Uric Acid	84550
22.	Triglycerides	84478
23.	Creatinine Phosphokinase (CPK)	82550, 82555
24.	Glutamyl transpetidase, gamma	82977

CLINICAL LABORATORY PROCEDURES REVIEWED
AUTOMATED HEMATOLOGY PROFILE AND COMPONENT TEST HCPCS

Hematology Component Test CPT Codes

Red Blood Cell Count (RBC) only	85041
White Blood Cell Count (WBC) only	85048
Hemoglobin, Calorimetric (Hgb)	85018
Hematocrit (Hct)	85014
Manual Differential WBC count	85007
Platelet Count (Electronic Technique)	85595

Additional Hematology Component Tests - Indices

Automated Hemogram Indices (one to three)	85029
Automated Hemogram Indices (four or more)	85030

Hematology Profile CPT Codes

Hemogram (RBC, WBC, Hgb, Hct and Indices)	85021
Hemogram and Manual Differential	85022
Hemogram and Platelet and Manual Differential	85023
Hemogram and Platelet and Partial Automated Differential	85024
Hemogram and Platelet and Complete Automated Differential	85025
Hemogram and Platelet	85027



State of Wisconsin
Department of Health and Social Services

Tommy G. Thompson, Governor
Joe Lee, Secretary

October 31, 1995

Paul Swanson
Regional Inspector General for Audit Services
Department of Health and Human Services, Region V
105 West Adams Street
Chicago, IL 60603-6201

Dear Mr. Swanson:

Thank you for the opportunity to comment on the draft audit report of your review of reimbursement for clinical laboratory services under the Wisconsin Medicaid program.

We have reviewed your findings and have the following summary comments to the audit findings and projected overpayments to Medicaid providers cited in your report:

No Violations of Federal Regulations:

- The report is incorrect in several significant, basic interpretations of Medicaid requirements.
- There are no federal requirements for Medicaid programs to limit reimbursement for unbundled lab panels.
- The scope and focus of the audit was not based on federal Medicaid requirements. Rather it was based on best practices, standard coding conventions and Medicare reimbursement requirements.
- The Medicare Carrier's Manual cited several times in the report is not applicable to Medicaid programs.
- The Wisconsin Medicaid program should not be liable for projected overpayments which are not violations of federal Medicaid requirements.

Wisconsin Followed Its Reimbursement Guidelines:

- Absent any federal regulations, Wisconsin established and implemented its own reimbursement policy for clinical laboratory based on standard coding conventions and best practices.
- The review led to no significant findings that Wisconsin did not follow its own reimbursement policy.

Paul Swanson
October 31, 1995
Page 2

The Audit Was Improper-Iv Completed:

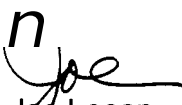
- Many of the findings and projected overpayments are based on incorrect application of the coding conventions and misunderstandings about Wisconsin Medicaid claims processing and reimbursement policy and procedures. Attached for your review are the Department's responses to the specific audit findings from your report.
- The limited volume and scope of the 100 claim sample compounded with our concerns significantly reduce the amount and confidence of projected overpayments.

Wisconsin Has Addressed OIG Review Issues:

- The Wisconsin Medicaid program is a leader in the use of sound reimbursement and "best practices" in claims processing that will result in Medicaid recipients receiving the highest quality service at the lowest cost.
- Wisconsin has demonstrated its performance by its excellent results in the **MMIS** Systems Performance Reviews.
- We have expanded our cost containment in the area of reimbursement of lab services by implementing **ClaimCheck** software, which further detects and corrects unbundled, mutually exclusive, and incidental services.
- We recommend that the HCFA not pursue recovery of overpayments in Wisconsin, based on our response to the audit findings and our improvements in claims processing.

Thank you, again, for the opportunity to provide input in this matter.

Sincerely,


Joe LEEAN
Secretary

Attachment

provided. We collect and use the detailed charges for documentation of services provided and to support cost audits of hospitals. The detailed charges for lab services are priced for reporting purposes and do not represent overpayments.

OIG Finding: State agency did not include codes 82374, 82550, 84160, 85023, 85024, 85025, 85027, 85029, 85030, and 85595 in instructions to providers,

Response: Wisconsin Medicaid physician handbook and other publications have historically instructed providers to use the CPT-4 coding manual and CPT-4 coding conventions for billing Medicaid. This alleviates the need to publish redundant and ever changing lists of codes in our provider manuals. Providers can use the standard CPT manual and their annual updates for guidance on billing.

Also in conjunction with implementation of **ClaimCheck**, our provider bulletin reminded providers that our procedure code rebundling and edits follow CPT coding conventions. Providers were reminded to consult instructions presented in CPT manuals in order to determine appropriate billing.

OIG Finding: State agency's claims processing system did not edit procedure codes 85023, 85024, 85025, 85027, 85029, 85030, and 85595.

Response: These codes should not be considered overpayments as there are not federal requirements to monitor these specific codes. While we agree it is good practice to monitor this area of hematology lab services, the State should not be held liable to recover payments where there are no specific federal mandates addressing this area.

We did identify this area as one in which we could improve monitoring and reduce payments via **ClaimCheck**. **ClaimCheck** does monitor hematology services in a more comprehensive basis than our standard claims processing edits.

Medicare Fee Schedule

OIG Finding: State agency's lab reimbursement rates exceeded Medicare fees.

Response: From historical experience in reviewing the Medicare Fee schedule compared to Wisconsin Medicaid rates, we project the extent and amount of potential overpayments will be minimal. Wisconsin Medicaid rates are historically very comparable to Medicare fees, and Medicaid rate increases, when allowed by the legislature, have not kept pace with the annual rate increase allowed by Medicare. We will correct our rates immediately to bring them in line with Medicare fees.

**Wisconsin Department of Health and Social Services Response to
OIG Draft Report on Medicaid Laboratory Reimbursement**

October 1995

The following is our response to the specific findings as presented in the draft report:

Chemistry and Hematology Panel Tests

OIG Finding: State agency's claims processing system did not edit claims for services in place of service inpatient and outpatient.

Response: These claims should not be considered as overpayments. It is inappropriate to apply claim edits to lab services billed in an inpatient or outpatient setting. The physician lab services billed in the hospital setting in your sample are for the professional component (interpretation) of the lab result. Reimbursement for the performance of the lab test (technical component) is included in the hospital rate. The lab panel billing and reimbursement limits are not applicable to professional lab charges.

Further, effective May 1994, Wisconsin Medicaid no longer reimburses most labs billed strictly as professional services.

OIG Finding: State agency's claims processing system did not edit for procedure codes 80050, 80058, and 82550.

Response: Claims for these codes should not be considered as overpayments. The first two codes are not considered automated multichannel lab profiles and code 82550 is not a test routinely included in profiles as defined in the CPT-4 physician's coding handbook or the Medicare Carriers Manual.

OIG Finding: State agency's claims processing system did not edit for services submitted on multiple claims.

Response: The majority of lab services performed on a single day are billed on one claim **form**. It is difficult and not cost effective or efficient to edit lab services billed on separate claim forms during a claims processing cycle. We are planning to use the **ClaimCheck** software retrospectively to identify and correct all unbundling on multiple claims for the same date not detected by claims processing edits and **ClaimCheck**.

OIG Finding: State agency's claims processing system did not edit type of service "C", ancillaries for hospitals and nursing homes.

Response: These examples are not overpayments. It is not necessary or appropriate to apply claim edits to lab services billed by outpatient ~~hospitals as~~ ancillary services due to the Wisconsin Medicaid reimbursement methodology for outpatient hospital services. We reimburse outpatient hospital services, including lab services, on a flat rate per visit regardless of the type or number of services